Commonwealth of Virginia

Application for Adult Medical Assistance

This is an application for Medical Assistance services for adults age 19 years or older who are blind or disabled, as well as for adults who are 65 or older. If none of these conditions apply to you, please contact your local department of social services (DSS) to obtain the correct application.

Medical Assistance may help pay hospital bills, doctor's visits, and Medicare premiums. Answer all of the questions to the best of your ability. Please remember to give complete and accurate information. If there is missing information, we may not be able to determine your eligibility for medical assistance.

To apply for benefits, follow these steps:

Step 1: Complete this application. You can access an electronic version of this application at **www.dss.virginia.gov**. Read the instructions carefully and give accurate information.

Step 2: Sign and date your application. If you and your spouse are applying, you both need to sign the application. If you are applying for someone else, please answer the questions as they relate to that person and sign the application.

Step 3: Once you have completed your application mail, fax, or bring it to your local DSS office. If you need help completing your application or if you have questions, please contact your local DSS office. A list of addresses and phone numbers of the local departments is available at **www.dss.virginia.gov**. You do not need to have an interview with local agency staff.

Step 4: Provide verification(s) and information as requested by the DSS.

Frequently Asked Questions

How long does it take to get benefits?

It takes about 45 days to process most Medical Assistance applications. If a disability determination is needed, it may take as long as 90 days.

Being prepared helps the process move smoothly. For anyone applying for Medical Assistance, the following information may be needed:

- Proof of identity, such as: ID card, driver's license
- Proof of citizenship, such as: birth certificate, certificate of naturalization
- Social Security numbers of everyone requesting assistance
- Proof of income, such as: pay stubs, child support, and income award letters
- Proof of resources, such as: bank statements

If you need assistance in gathering this information, please tell your worker.

How do you use my personal information?

We will use your personal information to determine eligibility for Medical Assistance.

To verify the information you give us, we use the Income and Eligibility Verification System (IEVS) and the State Verification Exchange System (SVES). We also match your information against Federal, State, and local records, including the Virginia Employment Commission, the Department of Motor Vehicles, the Internal Revenue Service, U.S. Citizenship and Immigration Services (formerly the Immigration and Naturalization Service or INS), and the Social Security Administration.

Section 1. General Information

Would you like to name a person who could apply for Medical Assistance benefits or receive correspondence and notices for you? ❑ Yes ❑ No If yes, please provide the following information in the space provided below.

_____ _____
Name of Representative Phone Number

_____ _____
Address (Street, P.O. Box, etc.) City, State, Zip

I want this representative to:
- ❑ Apply for and/or renew Medical Assistance
- ❑ Receive requests for information needed to determine eligibility
- ❑ Receive letters regarding actions taken on my case
- ❑ Other (specify): _____

Tell us who is applying for Medical Assistance

If you are completing this application for someone else, answer the questions as they relate to that person.

1. **Self**

Name | **Relationship to You** | **Date of Birth**

Street Address (include apartment number) | **Mailing Address** (if different from your street address)

City | **City**

State, ZIP | **State, ZIP**

( ) - | **( ) -**

Home Phone Number | **Daytime or Message Phone Number**

In what city or county do you live?

Social Security Number_____

Gender:
- ❑ Male
- ❑ Female

Marital Status:
- ❑ Married
- ❑ Never Married
- ❑ Divorced
- ❑ Widowed
- ❑ Separated

Virginia Resident:
- ❑ Yes
- ❑ No

Place of Birth (City, State, Country)

U.S. Citizen? ❑ Yes ❑ No

— If you are not a U.S. Citizen, please provide the following information:

Alien Registration Number | **Date started living in the U.S.**

Providing the following information is voluntary and will not affect eligibility. Please check all that apply.

Ethnicity:
❑ Hispanic/Latino ❑ Not Hispanic/Latino

Racial Heritage:
❑ White ❑ Black or African American
❑ Asian ❑ Native Hawaiian/Other Pacific Islander
❑ Other ❑ American Indian/Alaskan Native

Name of Tribe: _____

What is the primary language spoken in your household?

❑ English ❑ Vietnamese ❑ Laotian ❑ Somali ❑ French ❑ Spanish
❑ Farsi ❑ Chinese ❑ Kurdish ❑ German ❑ Japanese ❑ Cambodian
❑ Korean ❑ Haitian-Creole ❑ Arabic ❑ Other (specify): _____

Section 2. Household Information

Tell us about your spouse and about children under 21 years of age who live with you

2.

Name | **Relationship to You** | **Date of Birth**

Gender:
❑ Male
❑ Female

Marital Status:
❑ Married
❑ Never Married
❑ Divorced
❑ Widowed
❑ Separated

Assistance Requested:
❑ Medical Assistance
❑ None

Virginia Resident:
❑ Yes
❑ No

If the person listed in #2 above is not applying for medical assistance, you are not required to provide the information below.

Social Security Number: _____

Place of Birth: _____
(City, State, Country)

U.S. Citizen? ❑ Yes ❑ No

— If not a U.S. Citizen, please provide the following information:

Alien Registration Number | **Date Started Living in the U.S.**

Providing the following information is voluntary and will not affect eligibility. Please check all that apply.

Ethnicity:
❑ Hispanic/Latino ❑ Not Hispanic/Latino

Racial Heritage:
❑ White ❑ Black or African American
❑ Asian ❑ Native Hawaiian/Other Pacific Islander
❑ Other ❑ American Indian/Alaskan Native

Name of Tribe: _____

3.

Name | **Relationship to You** | **Date of Birth**

Gender:
- ❑ Male
- ❑ Female

Marital Status:
- ❑ Married
- ❑ Never Married
- ❑ Divorced
- ❑ Widowed
- ❑ Separated

Assistance Requested:
- ❑ Medical Assistance
- ❑ None

Virginia Resident:
- ❑ Yes
- ❑ No

If the person listed in #3 above is not applying for medical assistance, you are not required to provide the information below.

Social Security Number: _____

Place of Birth: _____
(City, State, Country)

U.S. Citizen? ❑ Yes ❑ No

— If not a U.S. Citizen, please provide the following information:

Alien Registration Number | **Date started living in the U.S.**

Providing the following information is voluntary and will not affect eligibility. Please check all that apply.

Ethnicity:
❑ Hispanic/Latino ❑ Not Hispanic/Latino

Racial Heritage:
- ❑ White
- ❑ Black or African American
- ❑ Asian
- ❑ Native Hawaiian/Other Pacific Islander
- ❑ Other
- ❑ American Indian/Alaskan Native

Name of Tribe: _____

If additional space is needed to add other family members please ask for an additional application form.

Please answer these questions for anyone who is applying for Medical Assistance

1. Has anyone in your household ever applied for or received any Medical Assistance from a social service agency in another state or Virginia city or county? ❑ Yes ❑ No

— If **yes**, please indicate which state or Virginia city or county below:

2. Is anyone in your household temporarily away from home? ❑ Yes ❑ No

— If **yes**, please provide the following information:

Name | **Date Left**

Reason for Leaving Where is the person currently staying?

Where is the person currently staying? | **Expected Return Date**

3. Has anyone in your household ever been determined to be disabled by the Social Security Administration?

❑ Yes ❑ No — If **yes**, please provide the name of the individual:

Name

Name

4. Did anyone applying for Medical Assistance receive a medical service during the last 3 months?

❑ Yes ❑ No

— If **yes**, for which months: _____

Complete questions 5-11 if any applicants are under age 65 years.

5. Are you or is anyone for whom you are applying disabled?

❑ Yes ❑ No

— If **yes**, please provide the name of the persons:

Name of Person **Name of Person**

6. Have you or anyone for whom you are applying ever applied for Social Security, Supplemental Security Income (SSI) or Railroad Retirement benefits as a disabled person? ❑ Yes ❑ No

— If **yes**, please provide the name of the persons and date of application:

Name of Person and Date of Application **Name of Person and Date of Application**

7. If the application for Social Security, Supplemental Security Income (SSI) or Railroad Retirement benefits was denied, did you file an appeal of the denial? ❑ Yes ❑ No

— If **yes**, please tell us the outcome of the appeal.

8. Has it been less than 12 months since the most recent application for Social Security, Supplemental Security Income (SSI) or Railroad Retirement benefits was denied? ❑ Yes ❑ No

9. Has the condition changed or worsened since the most recent application for disability was denied?

❑ Yes ❑ No

10. Do you or your spouse have a new medical condition since the most recent application for disability was denied? ❑ Yes ❑ No

11. Have you or your spouse ever received Supplemental Security Income (SSI), disability benefits from the Social Security Administration or Auxiliary Grant payments? ❑ Yes ❑ No

Has the payment stopped? ❑ Yes ❑ No

—If **yes,** explain whose payment stopped, when it stopped, and why it stopped.

Section 3. Long-term Care

Please answer questions 11-14 if you are applying for anyone who is in a nursing facility or assisted living facility, or who requires nursing home care or assistance to remain in the home.

12. Do you or your spouse need nursing facility care or help such as bathing, dressing, toileting, etc., so that you can remain in your own home? ❑ Yes ❑ No

—If **yes**, and there is a spouse who lives somewhere else, what is the name and address of the spouse?

(Note: Under Virginia law persons are considered married and legally responsible for each other until they divorce.)

13. Do you or your spouse live in one of the following:

❑ Assisted Living Facility (ALF) ❑ Nursing Facility ❑ Group Home ❑ Hospital or other Medical Facility

— If you checked one of the above, please provide the following information:

Name | **Date of Entry** | **In What County Was the Prior Address?**

Person's address prior to entering the facility

Facility Name | **Facility Address**

Was placement made by a State agency? ❑ Yes ❑ No

14. Does the individual in the nursing facility or requiring assistance in the home have long-term care insurance? ❑ Yes ❑ No — If **yes**, please provide the following information:

Name of Insurance Company | **Address** | **City, State, ZIP**

Policy Number | **Person(s) Insured** | **Is this a Partnership Policy?** ❑ Yes ❑ No

15. Have you or your spouse sold, transferred, placed in a trust/annuity, or given away any resources, such as your home or other real property, cash, bank accounts, or cars in the last sixty (60) months (5 years)?

❑ Yes ❑ No — If **yes**, please provide the following information:

Type of Property Transferred	$ Value at Transfer	$ Amount Received	Date of Transfer

From Whom **To Whom**

Explain the Reason for Transfer

Note: If more than one transfer has occurred, please attach documentation.

Section 4. Resources and Assets

16. Do you or your spouse have any money/cash on hand that is not in a bank? ❑ Yes ❑ No

— If **yes**, please provide the following information:

Name	$ Amount

17. Do you or your spouse have any of the following resources? ❑ Yes ❑ No

— If **yes**, please check the boxes that apply and provide the information requested below:

❑ Checking, Savings ❑ Deferred Compensation Plan ❑ Christmas Club
❑ Credit Union ❑ Certificate of Deposit (CD) ❑ Money Market Funds

1.

Owner Name **Co-Owner Name**

Name of Bank	Account Type	Account Number	$ Balance/Value

2.

Owner Name **Co-Owner Name**

Name of Bank	Account Type	Account Number	$ Balance/Value

3.

Owner Name **Co-Owner Name**

Name of Bank	Account Type	Account Number	$ Balance/Value

Is your income (Social Security or SSI benefits, retirement pension, wages, etc.) deposited directly into any of the accounts you listed? ❑ Yes ❑ No If yes, which account? _____

18. Do you or your spouse have any stocks or bonds, trust funds, pension plans, retirement accounts, trusts, annuities, promissory notes, or deeds of trust? ❑ Yes ❑ No

— If **yes**, please provide the following information:

1.

Owner Name		Co-Owner Name	
Where is the Account Held?	**Account Type**	**Account Number**	**$ Balance/Value**

2.

Owner Name		Co-Owner Name	
Where is the Account Held?	**Account Type**	**Account Number**	**$ Balance/Value**

3.

Owner Name		Co-Owner Name	
Where is the Account Held?	**Account Type**	**Account Number**	**$ Balance/Value**

19. Do you or your spouse have any life insurance? ❑ Yes ❑ No

— If **yes**, please provide the following information:

1.

Owner Name	Person Insured	Type of Insurance (whole life or term)	
Company Name	**Policy Number**	**$ Face Value**	**$ Cash Value**

2.

Owner Name	Person Insured	Type of Insurance (whole life or term)	
Company Name	**Policy Number**	**$ Face Value**	**$ Cash Value**

3.

Owner Name	Person Insured	Type of Insurance (whole life or term)	
Company Name	**Policy Number**	**$ Face Value**	**$ Cash Value**

20. Do you or your spouse have burial plots, burial arrangements, or trust funds for burial? ❑ Yes ❑ No

— If **yes**, please provide the following information:

Owner(s)	Item/Type	$ Value/Amount Owed
		$
		$

21. Do you or your spouse have real property, including home property, life rights/estates, shares in undivided heir property, land, buildings, or mobile homes? ❑ Yes ❑ No

— If **yes**, please provide the following information:

Owner(s)	Type of Property/Number of Acres	$ Value/Amount Owed
		$

Do you live on this property? ❑ **Yes** ❑ **No** **Is this property currently for sale?** ❑ **Yes** ❑ **No**

Is this property rented? ❑ **Yes** ❑ **No** **Do you receive money from this property?** ❑ **Yes** ❑ **No**

22. Do you or your spouse have any licensed or unlicensed cars, trucks, vans, boats, motor homes, recreational vehicles, utility trailers, motorcycles, or mopeds? ❑ Yes ❑ No

— If **yes**, please provide the following information:

Owner(s)	Year-Make-Model	$ Value/Amount Owed
		$
		$

23. Do you or your spouse have any property that is used in the operation of a business, such as farm equipment, tools, or livestock? ❑ Yes ❑ No

— If **yes**, please provide the following information:

Owner(s)	Type	$ Value	$ Amount Owed
		$	$

24. Do you or your spouse expect a change in resources this month or next month? ❑ Yes ❑ No

— If **yes**, please explain below and give the date the change is expected:

Date Change Expected

Section 5. Income

25. Do you or your spouse receive any of the following types of money from working? ❑ Yes ❑ No

(Check all that apply and provide us with the requested information)

- ❒ Wages/Salary
- ❒ Contract Income
- ❒ Commissions, Bonuses, Tips
- ❒ Earned Sick Pay
- ❒ Vacation Pay
- ❒ Farming/Fishing
- ❒ Babysitting/Daycare
- ❒ Other Self-employment
- ❒ Odd jobs
- ❒ Any other money from working

Name

Employer Name, Address or Phone Number

Type of Work

Gross Monthly Earnings

Pay Schedule
❑ Weekly ❑ Monthly
❑ Biweekly ❑ Other:_____
❑ Twice a Month

Next Pay Date

Name

Employer Name and Address or Phone Number

Type of Work

Gross Monthly Earnings

Pay Schedule
❑ Weekly ❑ Monthly
❑ Biweekly ❑ Other:_____
❑ Twice a Month

Next Pay Date

26. Do you or your spouse expect to start working? ❑ Yes ❑ No

(This includes all jobs: full time, part time, seasonal, temporary, self-employment, etc.)

— If **yes**, please provide the following information:

Name

Employer

$

Anticipated Monthly Earnings

Date Job Will Start

Pay Schedule
❑ Weekly ❑ Monthly
❑ Biweekly ❑ Other: _____
❑ Twice a Month

Employer Phone Number

First Pay Date

27. Do you or your spouse receive or expect to receive any of the following income? ❑ Yes ❑ No

(Check all that apply and provide the information below.)

- ❒ Social Security/SSI
- ❒ Railroad Retirement
- ❒ Black Lung benefits
- ❒ Military Allotment
- ❒ VA benefits
- ❒ Retirement Pension (410K, IRA, Keogh)
- ❒ Public Assistance
- ❒ Worker Compensation
- ❒ Unemployment benefits
- ❒ Training allowances
- ❒ Room/board income
- ❒ Workforce Investment Act
- ❒ Child support, alimony
- ❒ Rental Income
- ❒ Loans
- ❒ Trusts
- ❒ Annuities
- ❒ Interest, dividends
- ❒ Strike benefits
- ❒ Prize winnings
- ❒ Cash gifts or contributions
- ❒ Insurance settlement
- ❒ Inheritance
- ❒ Any other source of money

List all income you or anyone in your household receives or expects to receive

1.	$		
Name of Person	**Income Amount**	**Type of Income**	**How Often Received?**
2.	$		
Name of Person	**Income Amount**	**Type of Income**	**How Often Received?**
3.	$		
Name of Person	**Income Amount**	**Type of Income**	**How Often Received?**
4.	$		
Name of Person	**Income Amount**	**Type of Income**	**How Often Received?**

28. Did you or your spouse lose employment or have income terminated in the past three months?

❑ Yes ❑ No

— If **yes**, please explain provide the following information:

Name	**Type of Income**	**Last Date Received**

29. Does anyone help you pay, or lend you money to pay rent, utilities, medical bills, or any other bills?

❑ Yes ❑ No

— If **yes**, please provide the following information:

Person Receiving Money	**Person Providing Help**
Type of Help Received	**$** **Amount**
Does the money come directly to you?	❑ Yes ❑ No
Is this a loan?	❑ Yes ❑ No

29. (Continued)

Is repayment expected? ❑ Yes ❑ No

Person Receiving Money | **Person Providing Help**

Type of Help Received | **$ Amount**

Does the money come directly to you? ❑ Yes ❑ No

Is this a loan? ❑ Yes ❑ No

Is repayment expected? ❑ Yes ❑ No

30. Do you or your spouse expect any changes in the money you will receive within the next 60 days?

❑ Yes ❑ No

— If **yes**, please explain below and provide the date the change is expected:

Date Expected_____

Section 6. Medicare

31. Do you or your spouse have Medicare? ❑ Yes ❑ No

— If **yes**, please provide the following information:

1.

Policy Holder | **Person Insured**

Medicare ID Number | **Begin Date** | **End Date**

2.

Policy Holder | **Person Insured**

Medicare ID Number | **Begin Date** | **End Date**

Section 7. Other Health Insurance

32. Do you or your spouse have health insurance? ❑ Yes ❑ No

— If **yes**, please provide the following information:

1.

Person Insured | **Name of Insurance Company**

Policy ID Number | **Begin Date** | **End Date**

32. (Continued)

Type of Coverage:

- ❑ **Hospital**
- ❑ **Doctor**
- ❑ **Medicine**
- ❑ **Dental**
- ❑ **Mental Health**
- ❑ **Vision**
- ❑ **Medicare Extended**
- ❑ **Other:** _____

2.

Person Insured | **Name of Insurance Company**

Policy ID Number | **Begin Date** | **End Date**

Type of Coverage:
Check all that apply

- ❑ **Hospital**
- ❑ **Doctor**
- ❑ **Medicine**
- ❑ **Dental**
- ❑ **Mental Health**
- ❑ **Vision**
- ❑ **Medicare Extended**
- ❑ **Other:** _____

Section 8. Plan First

Plan First is a Medicaid Program that provides family planning services to both males and females. All Medical Assistance applicants 19-64 years old will be evaluated for Plan First if they do not qualify for full Medicaid benefits unless they tell us not to below. Applicants under 19 years and 65 years or older will be evaluated for Plan First by request below. List the names in the space provided.

☐ DO NOT evaluate these applicants for Plan First coverage: _____

☐ Evaluate these applicants for Plan First coverage: _____

Section 9. Commonwealth of Virginia Voter Registration Agency Certification

If you are not registered to vote where you live now, would you like to apply to register to vote here today? (Please check only one)

- ❑ I am already registered to vote at my current address, or I am not eligible to register to vote and do not need an application to register to vote.
- ❑ Yes, I would like to apply to register to vote. (please fill out the voter registration application form)
- ❑ No, I do not want to register to vote.

If you do not check any box, you will be considered to have decided **not to** register to vote at this time.

Applying to register to vote or declining to register to vote will not affect the assistance or services that you will be provided by this agency. If you decline to register to vote, this fact will remain confidential. If you do register to vote, the office where your application was submitted will be kept confidential, and it will be used only for voter registration purposes. If you would like help filling out the voter registration application form, we will help you. The decision whether to seek or accept help is yours. You may fill out the application form in private if you desire.

If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, you may file a complaint with Secretary of the Virginia State Board of Elections, Washington Building, 1100 Bank Street, Richmond, VA 23219-3497, phone (804) 864-8901.

Applicant Name | **Signature** | **Date**

(for agency use only)

Voter Registration form completed: ❑ Yes ❑ No

Voter Registration form given to applicant for later mailing (at applicant's request): ❑

Agency Staff Signature | Date

Section 10. Your Rights and Responsibilities

Read this section before signing the application

Reporting Changes

Remember that you must report the following changes for Medical Assistance Programs within 10 days:

- Change of physical address or mailing address.
- Change in the persons in the household — person left, person born, etc.
- Change in source of income, getting a new job, stopping a job, other benefits, etc.
- Change in rate of pay per hour/day, or number of hours worked per pay period.
- Change in the amount of monthly income received that is not from working.
- Change in resources, such as receiving or giving away a resource or resources exceeding the limits.
- Change in motor vehicles owned.
- Change in marital status.
- Person in home is no longer disabled.
- Other changes that may affect eligibility for a program or the type of coverage or amount of assistance.

If you are not sure whether to report a particular change, please discuss the change with your worker.

Additional Responsibilities

- I understand that Medicaid, and DMAS contractors may exchange information relating to my coverage with local agencies, to assist with application, enrollment, administration, and billing services.

- I understand that to receive benefits from the Medicaid program, I must agree to assign my rights and the rights of anyone for whom I am applying to medical support and other third-party payments to the Department of Medical Assistance Services. If I do not agree to assign my rights, I will be ineligible for Medicaid.

- I understand that all money I receive for diagnosis or treatment of any injury, disease, disability, or medical care support must be sent to the Third-Party Liability Section, Department of Medical Assistance Services, Suite 1300, 600 East Broad Street, Richmond, VA 23219.

- I understand that my signature on this application certifies, under penalty of perjury, that I am (unless applying for emergency services only) a U.S. citizen or alien in lawful immigration status.

- I understand that I have the right to file a complaint if I believe I have been discriminated against because of race, color, national origin, sex, age, disability, or religious or political beliefs.

- I understand that I must report ownership of all annuities my spouse and I have. I also understand that my spouse and I may have to name the Commonwealth of Virginia as the beneficiary on any annuity we may have in order for Medicaid to pay for long-term care services.

- I understand that I am authorizing the Department of Social Services to obtain verification/information necessary to determine my eligibility for Medical Assistance.

Appeal Rights

You have the right to request an appeal and to have a fair hearing of any action that affects eligibility for Medical Assistance. This includes the right to a timely decision made on this application, and timely notice of the decision in writing. The request for an appeal must be in writing.

By My Signature…

I declare that I fully understand this application for assistance and agree to the rights and responsibilities as described. I declare that I have given complete, accurate, and truthful information. I understand that if the information I give now or in the future is false, incorrect, or incomplete, or if I do not report changes as required, I will be breaking the law and could be prosecuted for perjury, larceny, or fraud.

I hereby authorize the Department of Social Services to obtain verification/information necessary to determine my eligibility for Medical Assistance.

Signature or Mark of Applicant	**Date**
Signature or Mark of Spouse, if Also Applying	**Date**
I completed this application myself.	❑ Yes ❑ No
I did not complete this application, but someone read it back to me when it was completed.	❑ Yes ❑ No
Witness to Mark, or Interpreter	**Date**
Signature of Worker	**Date**

Complete if applicant did not fill out the application.

Name of Person Who Filled Out This Application	**Date**
Address (Street, PO Box, etc.)	**City, State, ZIP**
Telephone	**Relationship to Applicant**